FILED
2010 Aug-31 PM 02:18
U.S. DISTRICT COURT
N.D. OF ALABAMA

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ALABAMA
NORTHEASTERN DIVISION

KAREN EVANS,	)	
	)	
Plaintiff,	)	
	)	
vs.	)	Civil Action Number
	)	**5:10-cv-0040-AKK**
MICHAEL J. ASTRUE, COMMISSIONER OF SOCIAL SECURITY ADMINISTRATION,	)	
	)	
Defendant.	)	

MEMORANDUM OPINION

Plaintiff Karen Evans ("Plaintiff") brings this action pursuant to Section 205(g) of the Social Security Act, 42 U.S.C. § 405(g), seeking review of the final adverse decision of the Commissioner of the Social Security Administration ("SSA"). This Court finds that the Administrative Law Judge's ("ALJ") decision - which has become the decision of the Commissioner - is supported by substantial evidence. Therefore, for the reasons elaborated herein, the Court **AFFIRMS** the decision denying benefits.

I. Procedural History

Plaintiff filed her applications for disability insurance benefits and for Supplemental Security Income ("SSI") benefits under Titles II and XVI, respectively, of the Social Security Act ("the Act") on January 31, 2006, (R. 75-78, 79-83), alleging a disability onset date of November 1, 2005.[1] (R. 75; 79). After an initial denial, (R. 58), Plaintiff requested a hearing before the ALJ on May 19, 2006, (R. 67), which was held on March 18, 2008, in Decatur, Alabama. (R. 23-47).[2] On March 27, 2008, the ALJ denied the claim. (R. 7-22). This denial became the final decision of the Commissioner of the SSA when the Appeals Council refused to grant review, and, therefore, a proper subject of this court's review. (R. 1-4). Having timely pursued and exhausted her administrative remedies, Plaintiff filed this action for judicial review pursuant to section 1631 of the SSA, 42 U.S.C. § 1383(c)(3).

At the time of the hearing, Plaintiff was 32 years old with an eleventh grade education. (R. 53). Plaintiff has not engaged in substantial gainful activity since August 15, 2006, the alleged onset of her disability. (R. 12, 47, 84). Her past

[1] Plaintiff originally alleged a disability onset date of November 1, 2005, but subsequently amended it to August 15, 2006. (R. 50, 85).

[2] A hearing commenced on July 5, 2007, but was interrupted due to Plaintiff's illness and reconvened on March 18, 2008. (R. 16, 48).

relevant work was as a cashier. (R. 17, 93). Plaintiff's disability report alleges she suffers from psuedo-seizures ("blackouts"), carpal tunnel syndrome, migraines, obesity, and depression/anxiety. (R. 92).

II. Standard of Review

The only issues before this court are whether the record reveals substantial evidence to sustain the ALJ's decision, *see* 42 U.S.C. § 405(g); *Walden v. Schweiker*, 672 F.2d 835, 838 (11th Cir. 1982), and whether the ALJ applied correct legal standards. *See Lamb v. Bowen*, 847 F.2d 698, 701 (11th Cir 1988); *Chester v. Bowen*, 792 F.2d 129, 131 (11th Cir. 1986). Title 42 U.S.C. §§ 405(g) and 1383(c) mandate that the Commissioner's findings are conclusive if supported by "substantial evidence." *Martin v. Sullivan*, 894 F.2d 1520, 1529 (11th Cir. 1990). The district court may not reconsider the facts, reevaluate the evidence, or substitute its judgment for that of the Commissioner; instead, it must review the final decision as a whole and determine if the decision is reasonable and supported by substantial evidence. *See id*. (citing *Bloodsworth v. Heckler*, 703 F.2d 1233, 1239 (11th Cir. 1983)).

Substantial evidence falls somewhere between a scintilla and a preponderance of evidence; "[i]t is such relevant evidence as a reasonable person would accept as adequate to support a conclusion." *Martin*, 849 F.2d at 1529

(quoting *Bloodsworth*, 703 F.2d at 1239) (other citations omitted). If supported by substantial evidence, this court must affirm the Commissioner's factual findings even if the preponderance of the evidence is against the Commissioner's findings. *See Martin*, 894 F.2d at 1529. While the court acknowledges that judicial review of the ALJ's findings is limited in scope, the court also notes that the review "does not yield automatic affirmance." *Lamb*, 847 F.2d at 701.

III. Statutory and Regulatory Framework

To qualify for disability benefits, a claimant must be disabled, which is defined as "the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairments which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months . . . ." 42 U.S.C. § 423(d)(1)(A); 42 U.S.C. § 416(i). A physical or mental impairment is "an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrated by medically acceptable clinical and laboratory diagnostic techniques." 42 U.S.C. § 423(d)(3).

Determination of disability under The Act requires a five step analysis. 20 C.F.R. § 404.1520(a)-(f). The Commissioner must determine in sequence:

(1) whether the claimant is currently employed;

(2) whether the claimant has a severe impairment;

(3) whether her impairment meets or equals one listed by the Secretary;

(4) whether the claimant can perform her past work; and

(5) whether the claimant is capable of performing any work in the national economy.

Pope v. Shalala, 998 F.2d 473, 477 (7th Cir. 1993); *accord McDaniel v. Bowen*, 800 F.2d 1026, 1030 (11th Cir. 1986). "Once the claimant has satisfied Steps One and Two, she will automatically be found disabled if she suffers from a listed impairment. If the claimant does not have a listed impairment but cannot perform her past work, the burden shifts to the Secretary to show that the claimant can perform some other job." *Pope,* 998 F.2d at 477; *accord Foote v. Chater*, 67 F.3d 1553, 1559 (11th Cir. 1995). The Commissioner further bears the burden of showing that such work exists in the national economy in significant numbers. *Id*.

IV. The ALJ's Decision

The ALJ determined that Plaintiff's "severe combination of impairments [of] pseudo-seizures, panic attacks, and major depressive disorder" met Steps One and Two.[3] (R. 12). In Step Three, the ALJ found that Plaintiff's impairments neither met nor equaled the requirements for any listed impairment. (R. 13).

[3] Additionally, the ALJ found that Plaintiff is obese and has a "history of bilateral ankle fractures." (R. 12).

In Step Four, the ALJ found that Plaintiff "has the residual functional capacity to perform a full range of simple routine repetitive light work with occasional contact with supervisors." (R. 13). However, the ALJ opined that she is "unable to perform any past relevant work" as a cashier, which was classified as light, unskilled work, because it "exceeds the claimant's residual functional capacity." (R. 17).

Lastly, the ALJ considered the Plaintiff's age, education, work experience, residual functioning capacity, and impairments, and determined that there are jobs that exist in significant numbers in the national economy that Plaintiff can perform. (R. 18). Based on the foregoing, the ALJ determined that Plaintiff is not disabled. (R. 19).

V. Analysis

A. Seizures

Plaintiff initially alleged disability due to seizure disorder. (R. 51, 92). However, in the March 18, 2008, hearing before the ALJ, her attorney of record at that time[4] confirmed that Plaintiff withdrew seizure disorder as a basis of her disability. (R. 26). Nevertheless, the ALJ included psuedo-seizures as part of

[4] At the time of the hearing, Plaintiff was represented by Rodney Baines. (R. 23). Plaintiff is currently represented by Darryl Hunt. *See* doc. 1.

Plaintiff's severe combination of impairments, (R. 12), and concluded that the medical evidence did not support the presence of valid seizure disorder. (R. 16). Plaintiff contends that the "ALJ states incorrectly [ ] that examinations and EEGs[5] have failed to report the presence of valid seizure disorder." Doc. 8 at 14; *see* R. at 16.

The ALJ's decision is supported by substantial evidence. Specifically, Plaintiff's CT scans on July 29, 2006, (R. 228), July 10, 2007, (R. 434), and July 27, 2007, (R. 454), and brain MRI on January 18, 2006, (R. 170), were "normal." Likewise, Plaintiff's EEGs on January 12, 2006, (R. 153), and August 8, 2006, (R. 291), were "normal." Neurologist, Dr. Stephen Suggs, interpreted the January 12, 2006, EEG and commented that a "[n]ormal EEG does not rule out a seizure disorder. Clinical correlation is advised." (R. 153). Dr. Suggs noted in his August 3, 2006, evaluation of Plaintiff that she was "negative for diagnosed seizures." (R. 285).

A second doctor, Dr. E.G. Norwood, interpreted the August 8, 2006, EEG and commented that "[t]he absence of epileptiform discharges on a single EEG does not exclude a diagnosis of seizures, but there is nothing on this record to

[5] Electroencephalogram ("EEG") is a test that detects abnormalities related to electrical activity in the brain.

establish the presence of a seizure disorder." (R. 291). Dr. Norwood saw Plaintiff again on August 15, 2006, when Plaintiff had a 24 hour ambulatory EEG. (R. 290). Dr. Norwood reported the following findings: "Epileptiform discharge is seen with left hemisphere focus. No electrographic seizure was recorded. [ ] Abnormal EEG because of left hemisphere epileptiform discharge. This would correlate with her clinical seizure disorder." *Id*.

While Dr. Norwood's report of August 15, 2006, data may be suggestive, it is not conclusive. Considering the evidence in total (including the normal scans and Plaintiff's decision to abandon her claim for seizures (R. 26)), the ALJ's decision that valid seizure disorder is not present is supported by substantial, objective medical evidence.

B. Mental Health Impairments

Next, Plaintiff argues that the ALJ failed to "properly consider[] mental health issues in the disability determination." Doc. 8 at 14. The ALJ considered major depressive disorder, and substantial evidence supports his decision to deny benefits.

Plaintiff was seen by Dr. Piotr Zieba at Alabama Psychiatric Services, PC on September 5, 2007. (R. 483). Dr. Zieba opined that Plaintiff suffered from major depressive disorder, panic disorder with agoraphobia, and scored her Global

Assessment of Functioning[6] ("GAF") of 50, which indicates "serious symptoms OR serious difficulty in social, occupational, or school functioning." *Id*. Dr. Zieba commented further that "the patient's functioning may be influenced by taking Ativan and Lortab that probably she is used to taking more liberally than needed in the home situation." *Id*.

The ALJ gave Dr. Zieba's opinion "little weight," (R. 17), because a month later on October 3, 2007, Dr. Gagan Dhaliwal evaluated Plaintiff and diagnosed her with panic disorder and major depressive disorder, and scored her GAF as 60, which indicates "moderate symptoms OR moderate difficulty in social, occupational, or school functioning." (R. 495). Dr. Dhaliwal noted also that Plaintiff 1) was able to relate to others, 2) was cooperative, 3) had good judgment, and 4) had no suicidal or homicidal thoughts, but that her mood was "anxious." (R. 494).

The ALJ included "major depressive disorder" in the combination of severe impairments he considered, (R. 12), but determined that Plaintiff's psychiatric evaluation and GAF score were "consistent with only moderate symptoms or a

[6] The American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders presents the Global Assessment of Functioning scale, which is widely used to score the severity of psychiatric illnesses.

moderate impairment in social, occupation, or school functioning," (R. 15).[7] Further, the ALJ found that "[a]lthough the claimant has been treated with medications for psychological impairments, there is no indication her impairments have resulted in significant limitations." (R. 17).

Subsequent to the ALJ's decision, Plaintiff was hospitalized from July 21 - 29, 2009, due to a suicide attempt. (R. 505-506). Upon discharge, Plaintiff was diagnosed with major depressive disorder with suicidal ideation, cluster B personality disorder, and seizure disorder. (R. 506). She received a GAF score of 30, which indicates "behavior influenced by delusion or hallucinations OR serious impairment in communication or judgment." The discharge summary states also that Plaintiff "was discharged in markedly improved condition without suicidal or homicidal ideation or psychotic symptoms and anticipates following up in the outpatient setting as described." *Id*.

Considering the new evidence, the ALJ's opinion is supported by substantial evidence. Despite the major depressive disorder diagnosis, the record does not establish that the impairment has severely limited Plaintiff's ability to

[7] It is also important to note that Plaintiff was sent for further psychiatric evaluation, but it appears that she did not follow through with getting treatment. (R. 186, 483; *see* 284). Unfortunately, the record demonstrates that she seeks treatment primarily through emergency room visits at times of crisis, and has not sustained for any significant period of time continuity of treatment for her impairments.

function such that she is disabled. Indeed, Dr. Dhaliwal determined that her impairment caused only mild to moderate limitations. (R. 497). Likewise, Dr. Robert Estock, who completed a psychiatric review on April 20, 2006, noted that Plaintiff had anxiety and panic attacks, (R. 179), but that her degree of functional limitation was mild to moderate, (R. 184), and her mental residual functional capacity in all areas was either not significantly limited or moderately limited. (R. 188). Dr. Estock commented further that 1) there is "no [history of] psychiatric [treatment] either outpatient or inpatient, 1/06 USD were positive for cocaine, barbituates and benziod, claimant denied any current use of uncontrolled substance, denies abuse, denies treatment, denies purchasing drugs but admits to using cocaine a few times," (R. 186.), and 2) "Claimant is able to remember locations and work like procedures. She is able to understand, remember and carry out short simply instructions. She may have moderate difficulty handling more detailed instructions but likely can handle even these if they are broken down into simple 1-2 step tasks and she is given adequate rehearsal time," (R. 190).

Considering the entire record, including the new evidence from July 21, 2009, the record does not establish that Plaintiff's impairments cause severe limitations such that she is disabled. Accordingly, the ALJ's decision is supported

by substantial evidence.

C. The ALJ Fully Developed the Record

Plaintiff asserts that the ALJ "failed in his duty to develop the record according great weight to a consultative psychiatrist who honestly stated that he was basing his opinion on Plaintiff's self-report while discarding and ignoring the opinions of neurologist who stated that Plaintiff was disabled." Doc. 8 at 16-17. This argument lacks merit. Dr. Dhaliwal completed a Medical Source Opinion Form (Mental); question IV. states, "If drug and/or alcohol use is relevant to this case, please answer the following question. If drug or alcohol use were to stop, would there be any change in the above-stated limitations?" (R. 498). Dr. Dhaliwal checked "No," and wrote further, "based on self report." Therefore, Dr. Dhaliwal's comment qualified only question IV., rather than the entire report, and cannot serve as a basis to conclude that the ALJ failed to develop the record.

Plaintiff also argues that the ALJ failed to fully develop the record because he erroneously concluded "that he would not give Dr. Stephen Sugg's opinion any weight [because] there was no evidence to support Dr. Sugg's opinion." Doc. 8 at 17. Plaintiff was seen by Decatur Neurology on January 1, 2006, August 3, 2006, and August 18, 2006. (R. 284-89). In January 2006, Dr. Suggs commented that "the patient appears to have migraines and spells of uncertain etiology. She

certainly *could* have disability from her migraines and her spells. They do seem to be fairly severe." (R. 289) (emphasis added). While this was Dr. Suggs' impression, neither this statement, nor the record, establishes that Plaintiff is disabled.

On August 3, 2006, Plaintiff was seen by Dr. Norwood, who commented that, 1) "she has a longstanding history of headache, recent constant headache for about 8 months," 2) "[p]ast history of headache and more recent constant daily headache. This may be analgesic rebound associated with her Lortab use." (R. 286-87). On August 17, 2006, Plaintiff was seen again by Dr. Norwood, who commented that, 1) her "[h]eadache has also been improved" and 2) they "discussed potential role of caffeine in headache management and she will moderate her caffeine intake very slowly." (R. 284).

Other treatment reports indicate that Plaintiff's headaches are manageable. On October 27, 2005, and January 19, 2006, Plaintiff's brain MRI was normal. (R. 154, 170). During Plaintiff's July 29, 2006, visit to Athens-Limestone Hospital, her history of present illness indicated that she takes "Lortab for her carpal tunnel and *occasional* migraines." (R. 201). On August 17, 2006, Dr. Norwood reported that Plaintiff 1) "has been significantly improved," 2) "[h]eadache has also been improved," and 3) is "currently off of all of her

medicines including Ativan, Klonopin, Xanax, Paxil, Lortab." (R. 284). During her most recent hospitalization on July 21, 2009, Plaintiff's discharge summary indicated, "Neurologic: no significant complaints." (R. 505).

Based on this record, the ALJ's decision to give Dr. Suggs' statement little weight is supported by substantial evidence. The objective medical evidence does not establish that Plaintiff's migraines cause her to be disabled. The ALJ was not required to develop the record further because it contained sufficient evidence for him to make an informed decision. *Doughty v. Apfel*, 245 F.3d 1274, 1281 (11th Cir. 2001).

V. Conclusion

Based on the foregoing, the court concludes that the ALJ's determination that Plaintiff is not disabled is supported by substantial evidence, and proper legal standards were applied in reaching this determination. The Commissioner's final decision is, therefore, AFFIRMED. The court will enter a separate order in accordance with the memorandum opinion.

Done the 31st day of August, 2010.

ABDUL K. KALLON
UNITED STATES DISTRICT JUDGE